FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039776

Facility Name: CARMEN MANOR NURSING HOME, INC.

Address: 1470 W. CARMEN AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: 773-878-7000 **Fax #** 773-878-8335

IDPA ID Number: 36-3954499-001

Date of Initial License for Current Owners: 1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) CARY DRAZNER, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	113	Intermediate (ICF)	113	41,358	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	113	TOTALS	113	41,358	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0				8
9	SNF/PED					9
10	ICF	39,112	301		39,413	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,112	301		39,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.30%

D. How many bed-hold days during this year were paid by Public Aid?
686 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [X]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	145,509	22,858	6,834	175,201		175,201		175,201			1
2	Food Purchase		162,865		162,865	(16,338)	146,527	(12)	146,514			2
3	Housekeeping	134,442	35,850		170,292		170,292	535	170,827			3
4	Laundry	29,505	10,306		39,811		39,811		39,811			4
5	Heat and Other Utilities			75,883	75,883		75,883	1,821	77,704			5
6	Maintenance	94,817	71,315	23,242	189,374		189,374	(9,884)	179,490			6
7	Other (specify):*							22	22			7
8	**TOTAL General Services**	404,273	303,194	105,959	813,426	(16,338)	797,088	(7,518)	789,569			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	788,591	15,546	41,640	845,777		845,777	(388)	845,389			10
10a	Therapy	77,162		3,057	80,219		80,219		80,219			10a
11	Activities	62,185	18,118	1,492	81,795		81,795		81,795			11
12	Social Services	102,825	35,872	5,138	143,835		143,835		143,835			12
13	Nurse Aide Training											13
14	Program Transportation			859	859		859		859			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,030,763	69,536	53,386	1,153,685		1,153,685	(388)	1,153,297			16
	C. General Administration											
17	Administrative	166,690		60,000	226,690		226,690	(5,852)	220,838			17
18	Directors Fees											18
19	Professional Services			311,189	311,189	(21,310)	289,879	(161,420)	128,459			19
20	Dues, Fees, Subscriptions & Promotions			59,431	59,431		59,431	(34,345)	25,086			20
21	Clerical & General Office Expenses	63,612	14,256	4,150	82,018		82,018	51,339	133,357			21
22	Employee Benefits & Payroll Taxes			263,538	263,538	16,338	279,876		279,876			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,272	2,272		2,272	1,118	3,390			24
25	Other Admin. Staff Transportation			1,442	1,442		1,442	111	1,553			25
26	Insurance-Prop.Liab.Malpractice			70,291	70,291		70,291	626	70,917			26
27	Other (specify):*							20,483	20,483			27
28	**TOTAL General Administration**	230,302	14,256	772,313	1,016,871	(4,972)	1,011,899	(127,940)	883,959			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,665,338	386,986	931,658	2,983,982	(21,310)	2,962,672	(135,846)	2,826,826			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

CARMEN MANOR NURSING HOME, INC.
0039776
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	16,338	
2	FOOD		16,338

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	21,310	
19	PROFESSIONAL FEES		21,310

To reclass cost of appealing real estate taxes

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. #0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			53,086	53,086		53,086	9,842	62,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,749	22,749		22,749	29,709	52,458			32
33	Real Estate Taxes					21,310	21,310	112,898	134,208			33
34	Rent-Facility & Grounds			239,500	239,500		239,500	(239,500)				34
35	Rent-Equipment & Vehicles			9,555	9,555		9,555	(8,929)	626			35
36	Other (specify):*							(324)	(324)			36
37	**TOTAL Ownership**			324,890	324,890	21,310	346,200	(96,304)	249,896			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,038	62,038		62,038		62,038			42
43	Other (specify):*	26,212			26,212		26,212	(26,212)				43
44	**TOTAL Special Cost Centers**	26,212		62,038	88,250		88,250	(26,212)	62,038			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,691,550	386,986	1,318,586	3,397,122		3,397,122	(258,362)	3,138,760			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,154)	30		9
10	Interest and Other Investment Income	(2,874)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(402)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(29,430)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,230)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(64,691)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (108,793)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(149,569)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (149,569)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (258,362)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
CARMEN MANOR NURSING HOME, INC.
ID# 0039776
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Marketing Salary	(26,212)	43	2
3	Charitable Contributions	(2,280)	20	3
4	Political Contributions	(2,650)	20	4
5	Theft/Loss	(1,518)	21	5
6	Out of State Seminar	(75)	24	6
7	Misc. Income - Jury Duty	(33)	10	7
8	C.O.P.E. Contribution	(182)	20	8
9	Accounting Fees	(6,250)	19	9
10	Real Estate Tax - Apt. Bldg.	(3,427)	33	10
11	Capitalized Repair & Maintenance	(12,509)	6	11
12	Auto Lease	(9,555)	35	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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37				37
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40				40
41				41
42				42
43				43
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79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(64,691)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(12)											(12)	2
3	Housekeeping					535							535	3
4	Laundry													4
5	Heat and Other Utilities				958	863							1,821	5
6	Maintenance	(12,509)			692	1,933							(9,884)	6
7	Other (specify):*				22								22	7
8	**TOTAL General Services**	(12,521)			1,672	3,331							(7,518)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(33)				(355)							(388)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(33)				(355)							(388)	16
	C. General Administration													
17	Administrative			(42,833)	714	36,267							(5,852)	17
18	Directors Fees													18
19	Professional Services	(6,250)		388	97	(155,655)							(161,420)	19
20	Fees, Subscriptions & Promotions	(34,542)		4	7	186							(34,345)	20
21	Clerical & General Office Expenses	(5,150)	(999)	7	74	57,407							51,339	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(75)				1,193							1,118	24
25	Other Admin. Staff Transportation					111							111	25
26	Insurance-Prop.Liab.Malpractice				86	540							626	26
27	Other (specify):*			1,055		19,428							20,483	27
28	**TOTAL General Administration**	(46,017)	(999)	(41,379)	978	(40,523)							(127,940)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(58,571)	(999)	(41,379)	2,650	(37,547)							(135,846)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(8,154)	11,824	16	1,000	5,156							9,842	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,874)	30,606		1,904	73							29,709	32
33	Real Estate Taxes	(3,427)	114,667		1,658								112,898	33
34	Rent-Facility & Grounds		(239,500)		(7,137)	7,137							(239,500)	34
35	Rent-Equipment & Vehicles	(9,555)				626							(8,929)	35
36	Other (specify):*		(324)										(324)	36
37	**TOTAL Ownership**	(24,010)	(82,727)	16	(2,575)	12,992							(96,304)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(26,212)											(26,212)	43
44	**TOTAL Special Cost Centers**	(26,212)											(26,212)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(108,793)	(83,726)	(41,363)	75	(24,555)							(258,362)	45

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	INTEREST INCOME	$ 882	CARMEN MANOR BLDG. PARTNERSHIP		$	$ (882)	1
2	V	34	RENTAL INCOME	239,500				(239,500)	2
3	V	36	DIVIDEND INCOME	109				(109)	3
4	V	32	INTEREST EXPENSE - MORT				31,488	31,488	4
5	V	30	DEPRECIATION				11,824	11,824	5
6	V	33	REAL ESTATE TAXES				114,667	114,667	6
7	V	21	OFFICE EXPENSES	999				(999)	7
8	V	36	PRIOR PERIOD ADJUSTMENT	215				(215)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 241,705			$ 157,979	$ * (83,726)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 17,167	$ 17,167	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	388	388	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	4	4	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	7	7	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,055	1,055	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	16	16	20
21	V								21
22	V	17	MANAGEMENT FEES	60,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(60,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,000			$ 18,637	$ * (41,363)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 958	$ 958	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		692	692	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		22	22	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		714	714	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		97	97	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		7	7	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		74	74	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		86	86	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		1,000	1,000	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		1,904	1,904	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		1,658	1,658	25
26	V	34	RENT	7,137	MAZEL MANAGEMENT		0	(7,137)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,137			$ 7,212	$ * 75	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 535	$ 535	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	863	863	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	1,933	1,933	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	(355)	(355)	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	38,436	38,436	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	285	285	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	186	186	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	57,407	57,407	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	1,193	1,193	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	111	111	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	540	540	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	19,428	19,428	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	5,156	5,156	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	73	73	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	7,137	7,137	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	626	626	30
31	V	19	HOME OFFICE	155,940	MANAGCARE, INC.	100.00%	0	(155,940)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	(975)	(975)	32
33	V	17	ADMIN. SALARY - AHUVA WEINREB		MANAGCARE, INC.	100.00%	(801)	(801)	33
34	V	17	ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%	(393)	(393)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 155,940			$ 131,385	$ * (24,555)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARMEN MANOR NURSING HOME, IN(# 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	YOSEF DAVIS	General Partner	Officer	48.00%	See Attached	10	16.67%	Alloc. Salary	$ 15,000	17-1	1
2						Allocation - InterCare			17,167	17-7	2
3	MOSHE DAVIS	Dir. Of Operations	Administrative	.3985%	See Attached	11.2	28.00%	Alloc. Salary	35,462	17-1	3
4						Allocation - Managcare			(831)	17-7	4
5	JOSHUA DAVIS	Operations	Administrative	.3985%	See Attached	4.4	11.00%	Alloc. Salary	14,808	17-1	5
6	AHUVA WEINREB	Administrative	Administrative	.3985%	See Attached	5	25.00%	Alloc. Salary	13,462	17-1	6
7						Allocation - Managcare			(92)	17-7	7
8	SHOSHANA BRAUN	Owner	Clerical	.3985%	See Attached	2.2	15.82%	Alloc. Salary	1,331	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 96,307		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	$ 103,000	$ 103,000	10	$ 17,167	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	2,330		10	388	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	25		10	4	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	44		10	7	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	6,328		10	1,055	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	95		10	16	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 111,822	$ 103,000		$ 18,637	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. INC.	996,360	4	$ 6,120	$	155,940	$ 958	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC.	996,360	4	4,420	1,820	155,940	692	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC.	996,360	4	139		155,940	22	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC.	996,360	4	4,562		155,940	714	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC.	996,360	4	620		155,940	97	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC.	996,360	4	44		155,940	7	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC.	996,360	4	470		155,940	74	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC.	996,360	4	549		155,940	86	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC.	996,360	4	6,392		155,940	1,000	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC.	996,360	4	12,167		155,940	1,904	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC.	996,360	4	10,593		155,940	1,658	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 46,076	$ 1,820		$ 7,212	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	996,360	4	$ 3,420	$	155,940	$ 535	1
2	5	UTILITIES	BOOKEEPING INC.	996,360	4	5,512		155,940	863	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	996,360	4	12,353		155,940	1,933	3
4	10	NURSING SALARIES	BOOKEEPING INC.	996,360	4	(2,266)	(2,266)	155,940	(355)	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	996,360	4	245,581	245,581	155,940	38,436	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	996,360	4	1,820		155,940	285	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	996,360	4	1,190		155,940	186	7
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	996,360	4	366,796	292,203	155,940	57,407	8
9	24	SEMINARS	BOOKEEPING INC.	996,360	4	7,624		155,940	1,193	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	996,360	4	708		155,940	111	10
11	26	INSURANCE	BOOKEEPING INC.	996,360	4	3,452		155,940	540	11
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	996,360	4	124,135		155,940	19,428	12
13	30	DEPRECIATION	BOOKEEPING INC.	996,360	4	32,945		155,940	5,156	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	996,360	4	464		155,940	73	14
15	34	RENT - BUILDING (RELATED)	BOOKEEPING INC.	996,360	4	45,600		155,940	7,137	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	996,360	4	4,000		155,940	626	16
17										17
18	17	ADMIN. SALARY - MOSHE DA	AVG HRS WORKED	40	4	(3,475)	(3,475)	11	(975)	18
19	17	ADMIN. SALARY - AHUVA WE	AVG HRS WORKED	20	4	(3,205)	(3,205)	5	(801)	19
20	17	ADMIN. SALARY - JOSHUA DA	AVG HRS WORKED	40	4	(3,537)	(3,537)	4	(393)	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 843,117	$ 525,301		$ 131,385	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	VDA		X	Mortgage			$	$ 510,269			$ 31,488	1
2	First Bank of Evanston		X	Auto Loan				13,963			1,679	2
3												3
4												4
5												5
	Working Capital											
6	Manufacturer's Bank		X	Loan Payable				352,500			21,069	6
7												7
8												8
9	TOTAL Facility Related						$	$ 876,732			$ 54,236	9
	B. Non-Facility Related*											
10	Supplemental Schedule										1,095	10
11	Interest Income		X								(2,874)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,779)	14
15	TOTALS (line 9+line14)						$	$ 876,732			$ 52,457	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocation - Mazel Mgmt	X		Interest Expense			$	$			$ 1,904	1
2	Allocation - Managcare	X		Interest Expense							73	2
3	Interest Income - Bldg Co.	X									(882)	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,095	21

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	116,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	111,898	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,102)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	117,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	21,310	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 30,232 For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	134,208	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	109,568	8
	1996	109,175	9
	1997	110,581	10
	1998	110,985	11
	1999	110,240	12

Accrual is Prior Year Tax bill * 1.03. $113,667 * 1.03 = $117,000

Line 2 includes $1,658 related party allocation

CM Apartments - $ 3,427 adjusted out on Page 5

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

CM APARTMENT BUILDING - All expenses have been adjusted out on page 5.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1975	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1975	1975	$ 667,212	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	110,747	2,595	20	5,538	2,943	31,538	9
10	FIRE ALARM			1996	45,781	1,174	20	2,289	1,115	11,445	10
11	FIRE PUMP			1996	4,900	126	20	245	119	1,164	11
12	SECURITY SYSTEM			1996	990	25	20	50	25	229	12
13	DOORS			1996		95	20		(95)		13
14	CABINET CONNECTOR			1996	1,544	40	20	77	37	379	14
15	FIRE PUMP & ALARM			1996	1,600	41	20	80	39	333	15
16	WINDOW REPAIRS			1997	1,012	26	20	51	25	191	16
17	CCTV SYSTEM			1997	1,209	139	20	60	(79)	251	17
18	SECURITY EQUIP			1997	1,240	32	20	62	30	207	18
19	HOOD/EXHAUST FAN			1998			20				19
20	ELEVATOR			1998	4,500	115	20	225	110	563	20
21	AWNING & PAINTING			1998	4,500	115	20	225	110	506	21
22	TV & VIDEO EQUIP			1998	3,330		20				22
23	ELEVATOR REPAIR			1998	1,000		20	50	50	100	23
24											24
25	PAGE 12-1 REP TOTALS				40,540	2,131		1,758	(373)	24,139	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				437,334	11,824		13,933	2,109	300,368	33
34	PAGE 12B TOTALS				72,183	2,490		5,933	3,443	6,479	34
35	PAGE 12A TOTALS				141,364	6,089		7,070	981	11,433	35
36	TOTAL (lines 4 thru 35)				$ 1,540,986	$ 27,057		$ 37,646	$ 10,589	$ 389,325	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR REPAIR			1998	693		20	35	35	70	9
10	FIRE PUMP			1998	5,542	142	20	277	135	831	10
11	WINDOWS			1998	17,597	451	20	880	429	2,273	11
12	STAIR SAFETY IMPROV			1998	2,860	73	20	143	70	322	12
13	LSC & POL			1998	1,645	42	20	82	40	191	13
14	CALL & PA SYSTEM			1998	2,569		20	128	128	256	14
15	SO EXHAUST SYST			1998	1,818	47	20	91	44	235	15
16	KITCHEN RISER			1998	1,128	29	20	56	27	145	16
17	FIRE DOOR			1998	1,057	27	20	53	26	110	17
18	ELEVATOR IMPROV			1998	3,419	88	20	171	83	456	18
19	EXHAUST SYSTEM			1998	2,832	73	20	142	69	367	19
20	EXHAUST SYSTEM			1999	1,801		20	90	90	158	20
21	WALLS & DOORS			1999	10,215	262	20	511	249	724	21
22	FLOORING			1999	10,712	275	20	536	261	670	22
23	WINDOW TREATMENTS			1999	6,102	1,494	20	305	(1,189)	407	23
24	FIRE PROTECTION			1999	2,650		20	133	133	188	24
25	DOORS			1999	1,977		20	99	99	149	25
26	OFFICE REMODELING			1999	47,113	1,208	20	2,356	1,148	2,552	26
27	RADIATOR COVERS			1999	2,210		20	111	111	120	27
28	FIRE DOORS			1999	577		20	29	29	34	28
29	LOCKS			1999	638		20	32	32	35	29
30	CARPET			1999	7,670	1,878	20	384	(1,494)	544	30
31	CCTV SYSTEM			1999	1,323		20	66	66	72	31
32	DOORS			1999	1,785		20	89	89	134	32
33	DOORS			1999	2,546		20	127	127	191	33
34	DOORS			1999	2,088		20	104	104	156	34
35	NRS CALL SYSTEM			1999	797		20	40	40	43	35
36	TOTAL (lines 4 thru 35)				$ 141,364	$ 6,089		$ 7,070	$ 981	$ 11,433	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOORS			1999	1,580		20	79	79	112	9
10	DOORS			1999	1,249		20	62	62	78	10
11	CCTV SYSTEM			1999	2,262	724	20	113	(611)	160	11
12	ELEVATOR REPAIR			1999	2,335		20	117	117	215	12
13	ACCESS DOOR			1999	723		20	36	36	63	13
14	EXHAUST SYSTEM			1999	2,524		20	126	126	221	14
15	DOOR			1999	1,050		20	53	53	66	15
16	PAINTING			1999	2,965		20	148	148	210	16
17	WALLPAPER			1999	6,172	1,511	20	309	(1,202)	464	17
18	LIGHT FIXTURE			2000	7,339		20	1,468	1,468	1,468	18
19	**ELEV REPAIR			2000	2,565	8	20	8		8	19
20	**REMODELING-H. DEPOT			2000	2,422	28	20	28		28	20
21	REMODELING - ECONO			2000	2,182	35	20	35		35	21
22	REMODELING - ECONO			2000	2,403	49	20	49		49	22
23	WINDOW TREATMENT			2000	12,151		20	2,541	2,541	2,541	23
24	CCTV SYSTEM & WIRING ($5,568 & $4,186 PER CAP PROJ)			2000	9,753	135	20	135		135	24
25	**OUTDOOR LIGHTING			2000	999		20	50	50	50	25
26	**REMODEL			2000	4,016		20	201	201	201	26
27	**PEDASTAL REPAIR			2000	2,409		20	120	120	120	27
28	**ELECTRICAL			2000	1,390		20	70	70	70	28
29	EMERGENCY EGRESS UPGRADE			2000	3,694		20	185	185	185	29
30											30
31	** ADDED AFTER 6/30/00 CAPITAL PROJECTION										31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 72,183	$ 2,490		$ 5,933	$ 3,443	$ 6,479	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1994	15,086	396	20	1,026	630	8,012	9
10	VARIOUS			1993	25,032	589	20	1,251	662	9,282	10
11	VARIOUS			1992	35,671	1,132	20	1,132		9,279	11
12	VARIOUS			1991	48,780	1,548	20	2,439	891	22,166	12
13	VARIOUS			1990	59,077	4,292	20	2,954	(1,338)	30,032	13
14	VARIOUS			1989	27,647	877	20	1,347	470	15,737	14
15	VARIOUS			1988	6,653	211	20	289	78		15
16	VARIOUS			1987	32,008	1,016	20	1,579	563	21,663	16
17	VARIOUS			1986	8,854	460	20	467	7	7,030	17
18	VARIOUS			1985	3,684	184	20	205	21	3,210	18
19	VARIOUS			1984	24,013	1,119	20	1,244	125	23,128	19
20	VARIOUS			1983	13,203					13,203	20
21	VARIOUS			1982	4,369					4,369	21
22	VARIOUS			1981	76,511					76,511	22
23	VARIOUS			1978	2,925					2,925	23
24	VARIOUS			1975	53,821					53,821	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 437,334	$ 11,824		$ 13,933	$ 2,109	$ 300,368	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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23											23
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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14											14
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16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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22											22
23											23
24											24
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985	MAZEL	$ 16,147	$ 840	35	$ 538	$ (302)	$ 8,208	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MANAGCARE, INC - ALLOCATION			1997	1,882	235	20	188	(47)	643	9
10	MANAGCARE, INC - ALLOCATION			1993	148	8	20	7	(1)	56	10
11	MANAGCARE, INC - ALLOCATION			1988	230	7	20	11	4	142	11
12	MANAGCARE, INC - ALLOCATION			1986	17,462	892	20	800	(92)	12,933	12
13											13
14											14
15											15
16	MAZEL MANAGEMENT - ALLOCATION			2000	171	1	20	2	1	2	16
17	MAZEL MANAGEMENT - ALLOCATION			1998	604	21	20	30	9	82	17
18	MAZEL MANAGEMENT - ALLOCATION			1997	563	14	20	28	14	94	18
19	MAZEL MANAGEMENT - ALLOCATION			1996	384	9	20	19	10	88	19
20	MAZEL MANAGEMENT - ALLOCATION			1995	87	2	20	4	2	24	20
21	MAZEL MANAGEMENT - ALLOCATION			1994	343	6	20	17	11	94	21
22	MAZEL MANAGEMENT - ALLOCATION			1993	202	6	20	10	4	75	22
23	MAZEL MANAGEMENT - ALLOCATION			1991	152	5	20	7	2	67	23
24	MAZEL MANAGEMENT - ALLOCATION			1990	236	5	20	12	7	122	24
25	MAZEL MANAGEMENT - ALLOCATION			1989	147	3	20	6	3	71	25
26	MAZEL MANAGEMENT - ALLOCATION			1987	335	7	20	8	1	321	26
27	MAZEL MANAGEMENT - ALLOCATION			1986	1,353	70	20	71	1	1,023	27
28	MAZEL MANAGEMENT - ALLOCATION			1985	94					94	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 40,540	$ 2,131		$ 1,758	$ (373)	$ 24,139	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 159,296	$ 27,670	$ 14,904	$ (12,766)		$ 39,527	37
38	Current Year Purchases	39,161	6,596	7,190	594		7,190	38
39	Fully Depreciated Assets	270,471	4,025	371	(3,654)		24,307	39
40								40
41	TOTALS	$ 468,928	$ 38,291	$ 22,465	$ (15,826)		$ 71,024	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	2000 Toyota Camry	1999	$ 20,600	$ 5,000	$ 2,060	$ (2,940)	5	$ 2,575	42
43		MANAGECARE Alloc.		7,096	735	758	23	5	6,151	43
44										44
45										45
46	TOTALS			$ 27,696	$ 5,735	$ 2,818	$ (2,917)		$ 8,726	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,137,610	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 71,083	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 62,929	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (8,154)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 469,075	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

CARMEN MANOR NURSING HOME, INC.
0039776
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
CARMEN MANOR, INC.	136,465	24,958	13,151	(11,807)	32,958
CARMEN MANOR (BUILDING COMPANY)	6,600				
MANAGECARE, INC.	16,155	2,700	1,745	(955)	6,541
MAZEL MANAGEMENT	76	12	8	(4)	28
INTER CARE, LTD.					
TOTALS	159,296	27,670	14,904	(12,766)	39,527
LINE 29: CURRENT YEAR					
CARMEN MANOR, INC.	38,582	6,017	7,151	1,134	7,151
CARMEN MANOR (BUILDING COMPANY)					
MANAGECARE, INC.	579	579	39	(540)	39
MAZEL MANAGEMENT					
INTER CARE, LTD.					
TOTALS	39,161	6,596	7,190	594	7,190
LINE 30: FULLY DEPRECIATED					
CARMEN MANOR, INC.		4,009		(4,009)	
CARMEN MANOR (BUILDING COMPANY)	246,164				
MANAGECARE, INC.	21,612		351	351	21,612
MAZEL MANAGEMENT	132				132
INTER CARE, LTD.	2,563	16	20	4	2,563
TOTALS	270,471	4,025	371	(3,654)	24,307
TOTALS (Should Tie to Totals on Page 13)					
CARMEN MANOR, INC.	175,047	34,984	20,302	(14,682)	40,109
CARMEN MANOR (BUILDING COMPANY)	252,764				
MANAGECARE, INC.	38,346	3,279	2,135	(1,144)	28,192
MAZEL MANAGEMENT	208	12	8	(4)	160
INTER CARE, LTD.	2,563	16	20	4	2,563
TOTALS	468,928	38,291	22,465	(15,826)	71,024

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 626 Description: Managcare Allocation - $626
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs	N/A					#VALUE!	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 54,942	$ 103,405	1
2	Cash-Patient Deposits	1,956	1,956	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	984,406	984,406	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,334	74,334	6
7	Other Prepaid Expenses	2,933	2,933	7
8	Accounts Receivable (owners or related parties)	171,586	103,553	8
9	Other(specify): See supplemental schedule	2,006	52,271	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,292,163	$ 1,322,858	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		709,800	14
15	Leasehold Improvements, at Historical Cos	280,529	699,434	15
16	Equipment, at Historical Cost	253,934	603,949	16
17	Accumulated Depreciation (book methods)	(140,449)	(1,386,124)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	5,850	5,850	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 399,864	$ 732,909	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,692,027	$ 2,055,767	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 564,204	$ 564,204	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	352,500	352,500	29
30	Accrued Salaries Payable	60,430	60,430	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,152	16,152	31
32	Accrued Real Estate Taxes(Sch.IX-B)		117,000	32
33	Accrued Interest Payable	2,631	5,182	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	23,334	35,788	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,019,251	$ 1,151,256	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	13,963	13,963	39
40	Mortgage Payable		510,269	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 13,963	$ 524,232	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,033,214	$ 1,675,489	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 658,813	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,692,027	$ #REF!	48

*(See instructions.)

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. **#** 0039776 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Employee Advances	2,006	2,006
Interest Receivable		5,145
CS Keyman Insurance		45,120
	2,006	52,271

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses	2,877	2,877
Patient Trust Fund		12,454
Due to Provident Life	708	708
Due to Mid America	333	333
Due to Managcare	6,259	6,259
Deferred Tax Liability	13,157	13,157
	23,334	35,788

OTHER NON CURRENT ASSETS:		
Security Deposit - Auto Lease	5,850	5,850
	5,850	5,850

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 610,986	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 610,986	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	206,027	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(158,200)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 47,827	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 658,813	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	CARMEN MANOR NURSING HOME #	0039776	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		610,986
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		610,986
Equity(Deficit) from Page 17 Col 1		658,813
Related Party		
Equity(Deficit)	-362258.45	
Income	83726.3	
		(278,532)
Combined Equity - End of Year		380,281

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,506,086	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,506,086	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	864	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 864	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,874	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,874	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	93,325	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 93,325	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,603,149	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	813,426	31
32	Health Care	1,153,685	32
33	General Administration	1,016,871	33
	B. Capital Expense		
34	Ownership	324,890	34
	C. Ancillary Expense		
35	Special Cost Centers	26,212	35
36	Provider Participation Fee	62,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,397,122	40
41	**Income before Income Taxes (line 30 minus line 40)****	206,027	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 206,027	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARMEN MANOR NURSING HOM # 0039776 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Misc. Income - Jury Duty	33
2	Bad Debt Recovery	63,060
3	Real Estate Tax Refund	30,232
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	93,325

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,456	1,495	$ 35,116	$ 23.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,771	7,281	117,849	16.19	3
4	Licensed Practical Nurses	15,795	16,809	272,361	16.20	4
5	Nurse Aides & Orderlies	38,312	40,062	332,463	8.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,117	5,397	77,162	14.30	8
9	Activity Director	1,546	1,762	21,314	12.10	9
10	Activity Assistants	5,902	6,199	40,871	6.59	10
11	Social Service Workers	7,532	7,777	102,825	13.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,447	18,908	145,509	7.70	15
16	Dishwashers					16
17	Maintenance Workers	9,596	9,960	94,817	9.52	17
18	Housekeepers	16,596	17,805	134,442	7.55	18
19	Laundry	3,315	3,666	29,505	8.05	19
20	Administrator	2,752	2,880	55,572	19.30	20
21	Assistant Administrator	704	720	12,979	18.03	21
22	Other Administrative	3,567	3,567	98,139	27.51	22
23	Office Manager					23
24	Clerical	5,677	6,181	63,612	10.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,570	2,714	30,802	11.35	31
32	Other Health Care(specify)					32
33	Other(specify)	540	540	26,212	48.54	33
34	TOTAL (lines 1 - 33)	145,195	153,723	$ 1,691,550 *	$ 11.00	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,834	1-3	35
36	Medical Director	Monthly	1,200	9-3	36
37	Medical Records Consultant	Monthly	4,032	10-3	37
38	Nurse Consultant	939	36,660	10-3	38
39	Pharmacist Consultant	Monthly	600	10-3	39
40	Physical Therapy Consultant	4	200	10a-3	40
41	Occupational Therapy Consultant	57	2,857	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,491	11-3	44
45	Social Service Consultant	96	5,139	12-3	45
46	Other(specify)				46
47	Intercare MDS Consultant	12	348	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,137	$ 59,361		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 1		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 1		53

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing Salary	540	540	$ 26,212	$ 48.54
	540	540	$ 26,212	$ 48.54

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Gottesman 1/1-12/31/00	Administrator	0	$ 55,571
Ralph Ricana 4/1-7/31/00	Asst. Admin	0	12,980
See Attached	Attached		98,139
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 166,690

B. Administrative - Other

Description	Amount
Management Fees - InterCare, LTD.	$ 60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 60,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Schmidt, Salzman & Moran	Legal Services	$ 18,810
Managcare - Home Office Exp	Bookkeeping	155,940
Midwest Appraisal Company	Appraisal	2,500
Commitment Consulting	Mgmt. Consultants	94,497
Frost, Ruttenberg & Rothblatt	Accounting	37,667
Personnel Planners	Unemployment Consultants	1,775
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 311,189

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,293
Unemployment Compensation Insurance	36,235
FICA Taxes	125,544
Employee Health Insurance	68,763
Employee Meals	16,338
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	3,120
Christmas Expense	936
Other Employee Benefits	9,648
TOTAL (agree to Schedule V, line 22, col.8)	$ 279,877

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	15,644
Health Care Worker Background Check	742
(Indicate # of checks performed 106)	
Licenses & Fees	2,475
Advertising & Promotion	29,430
Dues & Subscriptions	5,828
Intercare Allocation	4
Mazel Mgmt Allocation	7
Managcare, Inc. Allocation	186
Less: Public Relations Expense	( )
Non-allowable advertising	(29,430)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,086

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,272
Less: Out of State Seminar	(75)
Managcare, Inc. Allocation	1,193
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,390

**See instructions.

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CARMEN MANOR NURSING HOME, INC. # 0039776 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILCLTC - $4110**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **99** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **62,037**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **16,338** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%LN1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw